# Mitchell Court (Tauranga) Limited

## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Mitchell Court (Tauranga) Limited

**Premises audited:** Mitchell Court

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 22 November 2016 End date: 23 November 2016

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 20

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Mitchell Court is privately owned and operated and cares for up to 35 residents requiring rest home level care. On the day of the audit there were 20 residents. The service is managed by an owner manager (non-clinical) who is supported by a clinical nurse manager and a facility coordinator. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service has addressed one of five shortfalls from the previous certification audit around open disclosure.

Improvements continue to be required in relation to advance directives, analysis of quality improvement data, evaluation of activities plans and medication management.

This surveillance audit identified further improvements required in relation to informed consent, assessments, interRAI timeframes, interventions and evaluations.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents and families interviewed report that they are kept informed. Residents and their families are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Services are planned, coordinated and are appropriate to the needs of the residents. Quality goals are documented for the service. An owner manager and a clinical nurse manager are responsible for the day-to-day operations of the facility.

A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place.

Nursing cover is provided by two registered nurses. A registered nurse is always on call when not available on-site. There are adequate numbers of staff on duty to ensure residents care needs are met.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The recreation coordinator provides an activities programme for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Care staff and registered nurses who administer medication complete education and medication competencies.

All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

No restraints or enablers are being used by the service. Staff receive education and training on restraint minimisation.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 10 | 0 | 5 | 2 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 6 | 3 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate | Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their EPOA. Improvements are required around the signing of an admission agreement and the obtaining of consent for short stay residents.  Advanced directives are signed for separately. Not all clinically indicated ‘not for resuscitation’ orders, completed by the GP evidenced that this decision had been discussed with the family or EPOA. Not all advanced directives have been correctly documented. The previous audit finding related to advanced directives remains.  Three care assistants and the clinical nurse manager interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  Four of five resident files sampled have a signed admission agreement that includes consents. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes how complaints are managed and is in line with the requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission.  Interviews with six residents (including one respite resident) and three family members confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern.  One complaint has been lodged since the previous audit. The complaints register included all information and correspondence related to the complaint. Timeframes for responding to the complaint were met and the complaint has been resolved. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items the resident must pay for that are not covered by the agreement.  Regular contact is maintained with family, which was evidenced on the family communication form held in each resident’s file sampled. Two-three monthly residents’ meetings provide a forum for residents to discuss issues or concerns. Nine accident and incident forms sampled evidenced that families are notified following any adverse event.  Three family members interviewed stated they are kept informed about changes in their family member’s health condition and notified following any accident or incident. The previous audit finding related to open disclosure has been met.  The service has policies and procedures available for access to DHB interpreter services and residents. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Mitchell Court is privately owned and operated and provides rest home level care for up to 35 residents. On the day of the audit there were 20 residents living at the facility (including two residents on respite care).  A mission statement and associated values have been developed for the service. Quality goals and objectives are established and reviewed annually. The facility is part of the Cavell Group. This group, which is comprised of five aged care facilities, share policies and procedures, provide internal auditing support for each other and provide an avenue for collegial support. The group meets six-monthly.  The owner of the facility is the facility manager. The owner manager (non-clinical) is supported by a clinical nurse manager who has been in the role five months. The clinical manager is new to clinical management and has previous aged care experience as a registered nurse. A new registered nurse position has been created as a facility coordinator and the person commenced in the role the day before the audit. The facility coordinator had had previous aged care management experience.  The owner has owned the facility since 2011 and has been in the role of owner manager since June 2015. The owner manager has maintained more than eight hours of professional development activities related to managing an aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Quality and risk management systems are documented. Interviews with staff (three care assistants, clinical nurse manager, a kitchen manager and a recreation coordinator) confirmed their understanding of the quality and risk management programmes.  There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.  The quality and risk management programmes includes an internal audit programme and data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure areas. There is evidence that quality data is being analysed. A corrective action process is not always implemented where opportunities for improvements are identified. The results of monitoring are not consistently being communicated to staff. The previous audit finding remains.  The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored.  Falls prevention strategies are in place including the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are in place to reduce the number of falls for at risk residents. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. Nine incident forms were reviewed and all were completed appropriately and in a comprehensive manner. All incident/accident forms reviewed reflected appropriate follow-up actions taken by registered nursing staff. The five residents’ files reviewed demonstrated documented accident/incident forms for that resident. The events were also documented in the residents’ progress notes and documented that families had been advised of the adverse event.  Discussions with the owner manager and clinical coordinator confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP and pharmacist. Six staff files were reviewed (three care assistants, clinical nurse manager, one cleaner, one kitchen manager). Evidence of signed employment contracts, job descriptions, orientation and training were available for sighting. Annual performance appraisals for staff are conducted for all employees. Interviews with care assistants described the orientation programme, which includes a period of supervision.  The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. Components of education and training also include staff completing questionnaires and visual competency assessments. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Two RNs are employed by the service (the clinical nurse manager and the newly appointed facility coordinator). Each RN works 40 hours per week. An RN is available on call if not available on-site. Care staff are adequately rostered to meet the needs of the residents. Separate cleaning staff are employed by the service with care assistants undertaking the laundry.  Care staff interviewed reported that staffing levels and the skill mix are appropriate and safe. All residents and families interviewed advised that there is sufficient staffing on duty each shift. The roster is able to be changed in response to resident acuity. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Ten medication charts were reviewed (including a chart for one resident on respite care). There are policies in place for safe medicine management that meet legislative requirements. The medication charts reviewed identified that the GP had seen and reviewed the residents three-monthly. Shortfalls were identified around the charting of “as required medications” and over the counter preparations.  All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The staff interviewed could describe their role regarding medicine administration. Staff were observed to be safely administering medications. The administration sheets reviewed evidenced that medication was being signed for and there was no evidence of transcribing. Eye drops had been dated when opened. The medication fridge temperatures are recorded regularly and these are within acceptable ranges. There were no residents self-medicating on the day of audit. The documented standing orders does not currently meet standing order guidelines. The previous audit findings relating to medication management remains. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen can meet the needs of residents who need special diets and the chef works closely with the RN. The kitchen staff have completed food safety training. The kitchen manager and cook follow a five-weekly seasonal menu which has just been reviewed by a dietitian in October 2016. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses and care assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse [wound care nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GPs.  Interviews with the clinical manager and care staff demonstrated an understanding of the individualised care requirements and needs of the residents. Care plan interventions in the files reviewed did not always describe the interventions required in specific detail to guide the care staff.  There was evidence of pressure injury prevention interventions such as two-hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.  Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. On the day of audit the clinical manager advised there were no wounds. The clinical manager could describe the requirements of wound care documentation, pressure injury prevention and management and wound care.  Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. The clinical manager was able to describe access to wound and continence specialist input as required. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | A recreation coordinator is employed from 10 am to 4.30 pm, four days per week to operate the activities programme for all residents. On the day of audit residents were observed participating in a variety of activities. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed by the activities staff. The service is transitioning to new activity care plan documentation.  Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activity plan. The activities care plan is not being reviewed at the same time as the long-term care plan is reviewed. The previous finding related to the evaluation of the care plan remains open.  Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | In the residents’ files reviewed all initial care plans were evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six-monthly or earlier for any health changes. Not all care plans had been evaluated against the stated goals. The GP reviews the residents at least three-monthly or earlier if required. Evidence of three-monthly GP reviews were seen in all residents’ files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 14 October 2017) and preventative maintenance is completed. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place and appropriate to the complexity of service provided. There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. The clinical manager is the restraint coordinator. During the audit, there were no residents using a restraint or an enabler. Staff receive education and training around restraint minimisation and managing challenging behaviours. Staff understand the difference between an enabler and a restraint. The entrance to the facility is gated with the security code in a visible location on both sides of the gate. |

# Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.2  Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making. | PA Low | There was evidence in four of five files sampled that an admission agreement and written consents were signed by the resident or their EPOA on admission. The resident admitted for regular periods of respite had no signed consents and had not been provided with an admission agreement to sign for this or any previous admissions. | A resident who was admitted for regular periods of respite had not signed an admission agreement and had no other documented evidence of consent. | Ensure that all residents admitted for care have a signed admission agreement and all relevant consents are documented.  90 days |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Moderate | Four of four long-term resident files sampled have an advance directive on file. One of these is signed by the resident and the GP as for resuscitation. Two have been signed by the GP as resuscitation not being clinically indicated and there is no documented evidence that there has been discussion with the family around this. One advanced directive for a competent resident had been signed by the resident’s daughter (EPOA) and the GP as not for resuscitation. There was no documented evidence that resuscitation had been discussed with the resident. The resident admitted for respite did not have an advanced directive documented.  This previous finding remains an area for improvement. | i)Two of the five resident files sampled contain a clinically indicated ‘not for resuscitation’ order signed by the GP but there is no evidence of this being discussed with the family.  ii)One ‘not for resuscitation’ order for a competent resident has been signed by the GP and the EPOA. | i) Ensure when the GP completes a clinically indicated not for resuscitation order that there is documented evidence that this has been discussed with the family or EPOA.  ii) Ensure that the advanced directives are signed in accordance with all the legislative requirements.  30 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Clinical data is collected and analysed each month (e.g., falls, infections, skin tears, medication errors) and where required, corrective action plans are implemented. However, the corrective actions being implemented are not being consistently documented or the actions evaluated and signed out. There was evidence of regular audits being completed, as part of the quality management programme. Where this monitoring has identified areas for improvement, corrective action plans have not been consistently documented and the result of the monitoring communicated to staff. | i)Corrective actions have been implemented to reduce the incidence of falls and chest infections. The corrective actions that have been implemented have not been consistently documented, evaluated or signed off.  ii) Where scheduled monitoring has identified, areas requiring improvement (charting of prn medication, interRAI assessments, replacement of curtains) corrective action plans have not been consistently documented and the results of the monitoring have not been communicated to staff | i-ii) Where areas of improvements are identified, ensure that corrective plans are documented and once implemented, the plan is evaluated and signed off. Ensure the results of monitoring and the corrective action plans implemented are communicated to staff.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Mitchell Court has a documented medication policy which complies with all legislative and contractual requirements. Medication charts are prescribed by the GP and the medication charts are reviewed six-monthly. There is a process in place for medication reconciliation. Staff who administer medication complete an annual medication competency. Medication is securely stored. The documented standing orders in use do not specify the resident the standing orders apply to, the contraindications for each medication and consistently document the route for administration. There is a corrective action plan in place to discontinue the use of standing orders.  In the medication files reviewed, the GP had prescribed the medication to be administered to the resident on admission and then reviewed the medications prescribed at least every three months. Not all indications for use had been documented for ‘as required’ medications. One resident was being administered over the counter preparations (Omega and Joint Care) that had not been prescribed by a GP. These medications were discounted on the day of audit. | (i)Standing orders in use do not comply with organisational policy or MOH guidelines for the use of standing orders.  (ii)Seven of ten medication charts sampled did not have indications for use documented for ‘as required’ medication  (iii)One of ten signing sheets reviewed evidenced that over the counter preparations were being regularly administered that had not been prescribed by a medical practitioner | (i)Ensure that standing orders in use comply with all guidelines and legislative requirements.  (ii)Ensure that ‘indications for use’ are charted for all ‘as required’ medication.  (iii) Ensure that all medications and over the counter preparations to be administered to a resident are prescribed correctly.  60 days |
| Criterion 1.3.3.1  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Moderate | The registered nurse is responsible for all aspects of assessment and care planning. In three of four long-term care plans sampled, the initial assessment and the initial care plan had been completed by a registered nurse. One long-term resident had the initial assessment and initial care plan completed by an administration staff member. The interRAI assessments and the long-term care plans in the files sampled had all been documented by a registered nurse. | One of five resident files evidenced the initial assessment and the initial care plan were not completed and documented by a registered nurse. | Ensure that all initial assessments and initial care plans are completed by a registered nurse or enrolled nurse under the direction of the RN.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | In the files sampled, interRAI assessments where completed for all residents requiring an interRAI assessments but not all interRAI assessments were completed in the required timeframes. There is one RN trained in interRAI. Long-term care plans reviewed were completed within 21 days of admission.  One respite resident who was regularly admitted for periods of respite had not had an initial assessment completed on admission and the short-term care plan on file updated to reflect the change in health condition since the last admission. The initial assessments and the short-term care plan were completed and updated on the day of audit. | i) One of five resident files had not had the initial interRAI assessments completed within 21 days of admission.  ii) Two of five resident files had not had the interRAI assessment completed at last six-monthly.  iii)One respite resident who was regularly admitted for periods of respite, had not had an initial assessment completed for the current admission or the short-term care plan on file updated to reflect the recent change in health condition. | i-ii) Ensure that all interRAI assessments are completed within the required timeframes.  iii)Ensure that an initial assessment and an initial care plan is documented (based on the assessment information) for all respite residents for each admission.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The RN reviews information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to develop the care plan. All residents have been commenced on the interRAI and the service is currently aligning six-monthly interRAI assessments with the review of the long-term care plan. Interventions had not been documented in sufficient detail to guide the care staff in three off five files reviewed.  Wound assessment, monitoring and wound management plans were reviewed for seven wounds that have now healed and the wound care documentation was fully completed. | Interventions were not documented in sufficient detail to guide care staff for i) one resident with postural hypotension, chronic pain, short-term memory loss and at risk of malnutrition ii) one resident with mental health needs, Meniere’s disease and hearing loss, iii) one resident with short-term memory loss, back pain, macular degeneration and visual disturbance. | Ensure that interventions are documented in sufficient detail to guide the care staff.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | All long-term residents have an activity care plan with individualised goals and interventions that have been developed within the last six months. In the files sampled all long-term residents have had a six-monthly review of their activity plan, however the activity plan had had not been reviewed at the same time as the review of the long-term care plan. | Four of four activity plans had been reviewed six-monthly but the activity care plan review had not occurred at the same time as the review of the long-term care plan (ARC 16.5ciii). | Ensure that activity plans are reviewed as part of the review of the long-term care plan.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | The registered nurse completes an evaluation of the long-term care plan six-monthly. Short-term care plans were reviewed and signed out within 3 weeks or if the change in health condition had become chronic, the interventions were added to the long-term care plan. Not all sections of the long-term care plan had documented evaluations and not all care plans had been evaluated against the stated goals. | Three of five long-term care plans reviewed were not evaluated against the stated goals and not all sections of the care plan had been evaluated. | Ensure that care plans are evaluated against the stated goals and all sections of the care plan are evaluated at least six-monthly.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.